GUIDE TO YOUR HEALTH BENEFITS

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January 2014 - December 2014

What You Need To Know



Benefit plan year is now the same as the calendar year.



Changes to prescription drug plan for medicare-eligible retirees.



Separate out-of-pocket maximums for copays and coinsurance lowering your costs!



Current benefit elections will rollover each benefit plan year unlessyou make changes during Open Enrollment. (Exception: You must re-enroll in the FSA each year.)



Keep track of your username and password for each vendor in the back of this guide.

Please read this guide carefully for details on these and many other topics.



Martin O'Malley, Governor

Anthony Brown, Lt. Governor

David C. Romans, Deputy Secretary

Welcome Agency Benefit Coordinator **Training**



Agenda

- Open Enrollment Update
- Healthcare Reform Update
- Employer Group Waiver Plan (EGWP)
- Retiree Health Information
- EBD Updates

Frequently Asked Questions

Throughout the presentations we will be reviewing frequently asked questions. Answer on the sheet in your folder, and we will review at the end of the training session.

Frequently Asked Question #1

What are the four pieces of documentation needed for grandchildren?



Active & Satellite Agency Employees and State Retirees

Open Enrollment

October 1, 2013 - October 16, 2013

Correction Period

October 22, 2013 - October 31, 2013

For important information regarding benefit changes for the new plan year, refer to the Open Enrollment materials mailed to your home or provided to you by your Agency Benefits Coordinator for details

Open Enrollment is your opportunity to enroll in the various benefit plans offered by the State of Maryland or to make changes to your current benefits coverage elections

DETAILED OPEN ENROLLMENT INFORMATION IS AVAILABLE ON OUR WEBSITE AT:

www.dbm.maryland.gov/benefits

Department of Budget & Management
Employee Benefits Division
410.767.4775 or 1.800.307.8283 or EBD.mail@maryland.gov





Open Enrollment Postcard

Mail Date: August 14, 2013

STATE OF MARYLAND EMPLOYEE AND RETIREE OPEN ENROLLMENT IS COMING SOON!



Plan Year is NOW January 1, 2014 to December 31, 2014



Medicare-eligible retiree prescription drug coverage change



Healthcare Reform plan changes



Get Open Enrollment information via web, twitter, health fairs, etc.

Visit our website for details and updates: www.dbm.maryland.gov/benefits

OPEN ENROLLMENT IS COMING!

PLAN YEAR: January 1, 2014 to December 31, 2014

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE
PAID
LANCASTER, PA
PERMIT #1793



Frequently Asked Question #2

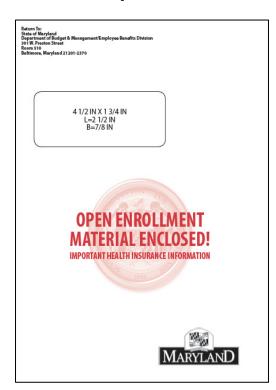
If an employee does not pay a mandatory retroactive adjustment or a no pay invoice, EBD will not cancel benefits. How will EBD obtain payment for these invoices?

Mark Your Calendars

- September 9, 2013: packets mailed to retirees, ORP, and Direct Pay enrollees.
- September 10, 2013: packets delivered to agencies.
- October 1, 2013 to October 16, 2013: CY14 **Open Enrollment**
- October 22, 2013 to October 31, 2013: Correction Period
- October 31, 2013: Postmark due date
- November 5, 2013: Forms due to EBD by COB

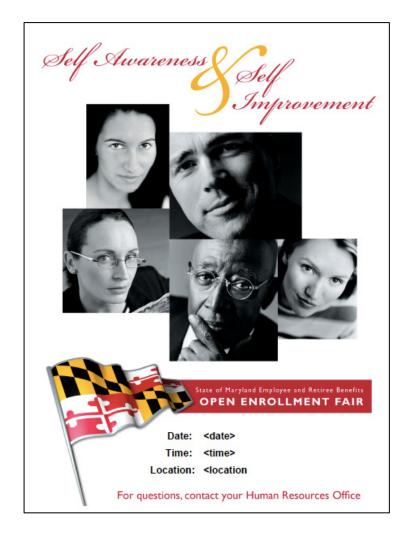
Open Enrollment Packets

- Summary Statement (info as of 8/17/13)
- Full Benefits Guide
- Instructions for making changes
- Enrollment forms (retirees, direct pay, ORPs)
- Health Insurance Marketplace
 Notice (active employees)
- EGWP Notice (Retirees/ORPs)
- Rates



Health Fairs

If you are hosting a health fair, we have created a health fair poster for you to use.



Questions



Frequently Asked Question #3

Same sex domestic partners may have coverage on an employee/retiree's coverage until what date?

Hot Topics for CY 2014

- Healthcare Reform
- Individual Mandate
- Defense of Marriage Act (DOMA) repeal
- Employer Group Waiver Plan (EGWP)

Effective January 1, 2014

Dollar Limits Eliminated

- Hearing aids basic model
- IVF treatments (3 attempts per live birth)
- Medically necessary wigs

Key Points:

- Frequency limitations are still in effect for these benefits.
- All services must be received in-network.

Copay Out-of-Pocket Maximum

- Applies to PPO, POS, EPO and Behavioral Health
- Separate from deductible/coinsurance out of pocket maximum
- \$1,000 individual/\$2,000 family
- Applies to all copays (including emergency room)

Frequently Asked Question #4

You have surgery at an in-network hospital. The anesthesiologist & assistant surgeon are out-of-network specialist. Will their claims be paid in-network or out-of-network?

Individual Mandate

- What is the Individual Mandate?
- Who does the Individual Mandate apply to?
- Health Insurance Marketplace Notice
 - Summary of rights
 - Must be given to ALL employees by the ABC regardless of status
 - All new hires beginning 10/1/13
 - Satellite accounts are responsible for distributing their own notice. Model notice found at

http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf

Health Insurance Marketplace Notice



Health Insurance Marketplace Coverage Options and Your Health Coverage



PART A: General Information

When key parts of the health care law take affect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer. For employees of the State of Maryland coverage is provided under the State of Maryland's State Employee and Retiree Health and Welfare Benefits Program (the Program).

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to your at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provided does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium

If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer's contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is excluded from income for Federal and State income tax purposes.



Health Insurance Marketplace Coverage Options and Your Health Coverage



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in which an eligible dependent child nal criteria must be met for

lovee and Retiree Health and Welfare cal plan election is combined with In addition, the Program offers several dard for most full-time permanent 767.4775 or (800)492.5909, or view

How can I get more information?

For more information about the coverage offered under the State of Maryland's State Employee and Retiree Health and Welfare Benefits Program, please check the plan documents or contact the Department of Budget and Management's Employee Benefits Division at (410) 767.4775 or (800) 492.5909, or view our website at www.dbm.maryland.gov/benefits.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area (including Maryland).

PART B: Information about Health Coverage Offered by Your Employer

This Section contains information about health coverage offered by your employer. If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name	State of Maryland – Department of Budget and Management 301 West Preston Street, Room 510 Baltimore		4. Employee Identification Number (EIN) 6. Employer Phone Number		52-6002033	52-6002033	
5. Employer Address					(410) 767.4775		
7. City			8. State	MD	9. Zip Code	21201	
10. Who can we contact	t about employee heal	Ith coverage at	t this job?	Employee	Benefits Division	7.30.07.00.03	
11. Phone number (if different from above N/A		N/A	12. Email Address		ebd.mail@maryland.gov		

Here is some basic information about health coverage offered under the State of Maryland's State Employee and Retiree Health and Welfare Benefits Program:

- . We offer a health plan to:
 - o All permanent employees,
 - o Contractual employees, and
 - Part-time employees,
- · With respect to dependents, we offer a health plan to:
 - Spouse (opposite and same sex)
 - - · Biological children,
 - Adopted children,
 - Step-children.
 - Legal Wards.
 - · Other child relatives, and
 - Disabled children

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is not less than 60 percent of such costs.

Frequently Asked Question #5

If your employee receives a no pay letter while on a leave of absence due to an on-the-job injury, how do you instruct your employee to pay the missed premiums?

Defense of Marriage Act DOMA

- Repealed June 26, 2013
- Applies to married same-sex couples who reside in states that recognize same-sex marriages
- States include: CA, CT, DE, IA, ME, MD, MA, MN, NH, NY, RI, VT, WA, and District of Columbia

Defense of Marriage Act DOMA

- Imputed income and post tax premiums will not apply to married same-sex couples who reside in these states.
- Flexible Spending Accounts
 - Same-sex spouse and children now eligible
- Employee Refund
 - Employees should contact their tax advisor
- Updated Affidavit available online

Questions



Frequently Asked Question #6

Why do employees have to re-enroll in the FSA accounts each open enrollment?

Employer Group Waiver Plan (EGWP)

- Medicare Part D Basics
- What is it?
- Why is the State moving to it?
- What does it mean to retirees?
- How do retirees get more information?

Medicare Part D Basics

- 2014 Standard Part D Plan
 - \$310 deductible
 - Initial Coverage Period
 - Part D pays 75%; participant pays 25%, up to \$2,850 of total drug costs
 - Coverage Gap (donut hole)
 - participant pays 47.5% of brand name drugs; 72% of generic drugs
 - Catastrophic Coverage
 - Once total drug cost reach \$4,550, Part D pays 95%, participant pays 5% to end of calendar year

EGWP — What is It?

- Employer Group Waiver Plan
- Wraps the current prescription drug benefits around Medicare Part D Standard plan
- Applies to <u>Medicare-eligible retirees</u> only
 - Medicare eligibility due to age OR disability
 - U.S. residents only
 - Non-U.S. residents remain in current plan
- Medicare is primary payor, State is secondary
- State plan fills in gaps
- If already enrolled in an individual Part D plan, will be dis-enrolled and moved to this plan

EGWP – Why is the State Moving to This Type of Plan?

- Healthcare reform improved the administration and cost savings to employers
- Savings can be used to offset Other Post Employment Benefits (OPEB) liability
- Reduces cost of program without cutting benefits

- Seamless to retiree still just one ID card
- No change in copays or out of pocket limits
- Brand name differential eliminated
- Various quantity limits, step therapy, and prior authorizations eliminated
- No contraceptive restrictions
- Legend vitamins covered
- Three out of network fills per year permitted
- Expanded formulary
- Lower prescription drug premiums!

- Extra Help Low Income Subsidy
 - Retirees who qualify for low income assistance receive reduced copays and monthly premium reimbursement from CMS
- Social Security charges a penalty on the Part D premium for high income retirees (\$85,000+)
 - High-income earners may need to pay an additional Part D amount to the Federal government (\$85,000 for individuals/\$170,000 for married) this is known as D-IRMAA. Members will receive a letter from the Social Security Administration if they are identified as needing to pay this extra amount.

- Formulary disruption
 - ~1,500 members taking prescriptions that will become non-preferred
 - ~1,000 taking prescriptions that will become preferred
- Pharmacy disruption
 - 29 pharmacies not in Medicare network
 - 19 are VA; member can still use VA benefits card to fill Rx at these locations
 - less than 1% of participants impacted

- Members communications and ID cards will be mailed at the individual level (as per Medicare requirements).
- Slight differences in appeals process –
 Medicare process calls for 2nd level to go to an
 Independent Review Organization (IRO) with
 3rd-5th level being ruled on by an
 Administrative Law Judge.

Transition Supply Services

- CMS requires EGWPs to provide a transition supply for members who are impacted when a drug is restricted in some way
- The transition supply allows a member to receive up to a one month supply of a non-formulary Part D drug or a Part D drug with a prior authorization or other restriction without having the prescription rejecting at the pharmacy
- The Transition Supply Service does not apply to non-Medicare Part D drugs

EGWP – Open Enrollment

- ESI sends pre-note early-September
- Retiree can choose to opt-out
 - but then has no prescription coverage
 - drops prescription coverage via enrollment form or IVR
- Targeted mailings to any retirees disrupted by formulary change or network change

Prenotification Package

- CMS requires Medicare Part D plans to send a notification to members at least 21 days prior to the plan's effective date, notifying them that they will be group enrolled into the EGWP.
- packages are scheduled to begin mailing in early-September to align with Open Enrollment.

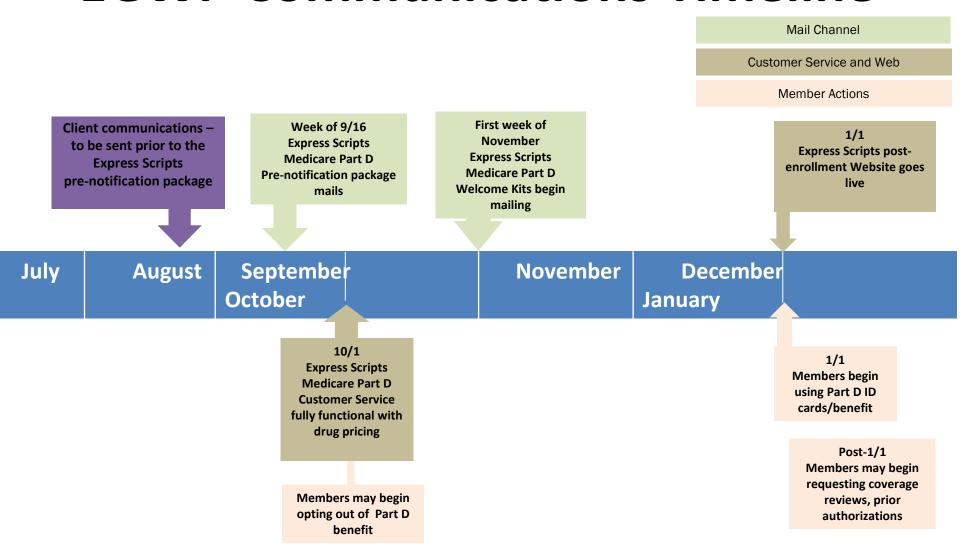
Standard Medicare Part D Prenotification Package Contents

- Prenotification Letter
- Benefit Overview

Opt-out Process

- The pre-notification package will provide information on the benefit and will advise the member they have the opportunity to opt out of the plan.
- Members will be enrolled in the Medicare Part D plan, unless
 - they call the IVR and cancel coverage or
 - submit an enrollment form canceling coverage
 - Must do either within 21 days of receiving the pre-notification letter
- If a member decides to opt out, the Retiree and the dependents will lose RX coverage through the State Program

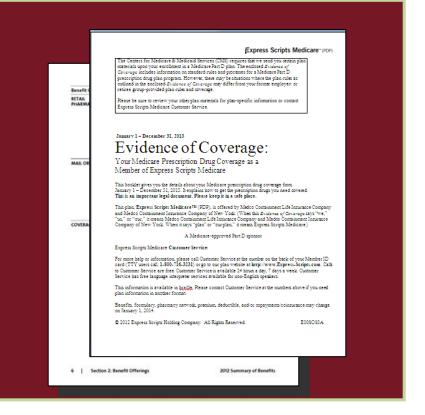
EGWP Communications Timeline



EGWP Communications

CMS Requires That Plan Sponsors Send Certain Communications to Members Regarding Their New Part D Plan

- Pre-notification mailing
- Enrollment and disenrollment letters
- Welcome kit package
- Plan administration mailings
- Explanation of Benefits
- Annual Notice of Changes (ANOC)
- Respond to CMS guidance as needed throughout the year



Welcome Kit Packages

- Sent to retirees early November for January 1 effective date
- Sent to new enrollees within 10 days of enrollment

Standard Welcome Kit

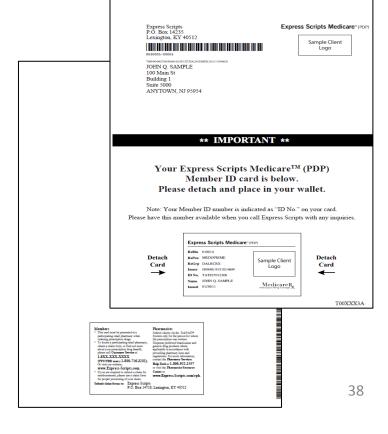
- Cover/Welcome Letter
- ID Card
- Benefit Overview
- Privacy Notice
- Evidence of Coverage
- LIS Rider (where applicable)

- Mail-Order Form
- Health Assessment Questionnaire
- Formulary
- Pharmacy Directory

Member ID Card

Member ID cards are included in Welcome Kits, Group Transfer packages, and sent upon member request. The ID card contains important information, such as the Member ID number needed to fill prescriptions. The back of the card includes the Express Scripts Customer Service phone number and the Pharmacy Help Desk phone number.

The Member ID card is located on the bottom third of the address carrier (this is the first document within each mailing)



Enrollment/Disenrollment Letters

• Enrollment/Disenrollment Letters

 Enrollment/disenrollment letters provide details on member enrollment, disenrollment and late enrollment penalty status. These letters are sent within 10 days of CMS response and may begin mailing after the production file has been processed.

Plan Administration Mailings

Express Scripts is responsible for all mailings related to Plan Administration.
 Plan administration mailings are sent to members to notify them of certain changes or programs such as MTM, Formulary 60 day and Transition Supply.
 Plan administration materials start mailing after the plan's effective date.

Explanation of Benefits (EOBs)

 Monthly statements available to members who have had claims processed in the previous month. EOBs are specific to Medicare Part D and include all claim information, along with True-out-of-Pocket (TrOOP) costs and drug spend information for the member.

Late Enrollment Penalty (LEP)

The LEP is a financial penalty incurred by Medicare beneficiaries who have had a continuous gap in coverage of 63 days or more at any point after the beneficiary's Initial Enrollment Period

LEP is assessed at 1% of the national base beneficiary premium for the coverage year, times the number of uncovered months.

- For example:
 - 1% X \$31.20 (national base beneficiary premium amount in 2012) X 5 (number of uncovered months) = \$1.55
- The LEP amount may change from year to year as national base beneficiary premium changes

EGWP Spouse Coverage Policy

If the Member is:	Non working Spouse	Plan for Spouse	
Working & MED D Eligible	NOT MED D Eligible	Commercial	
	MED D Eligible		
Working & Not MED D Eligible	NOT MED D Eligible	Commercial	
	MED D Eligible		
Retired & Not MED D Eligible	NOT MED D Eligible	Commercial	
	MED D Eligible	EGWP	
Retired & MED D Eligible	NOT MED D Eligible	Commercial	
	MED D Eligible	EGWP	

EGWP Customer Service Overview

- Customer Service Representatives are specifically trained in Medicare and in handling calls from the Senior population.
- Express Scripts Reps will begin taking calls from members during Open Enrollment period on October 1, 2013 for general questions
- Reps will be trained on items specific to the State of Maryland plan designs.
- Reps are available 24 hours a day/7 days a week.

EGWP Customer Service Overview

- Language interpreter services are available in 30+ languages.
- Representatives have access to Medic (Express Scripts portal containing client-specific information) and eSD to assist members.
- PDFs of materials are available to Representatives to better understand what concerns members may be calling about.
- On January 1, 2014, Customer Service Reps can address plan specific drug pricing, provide copies of CMS-required documents, prescription history, members may order prescription refills, or check the status of a home delivery prescription.

Member Services

- Members will be able to call a dedicated 800# for any EGWP related questions, 24/7
- Members will have access to <u>www.Express-</u>
 <u>Scripts.com</u> for all pharmacy information (i.e., drug coverage, pharmacy look-up, order tracking, etc.).
 - All CMS required materials will be posted on the website and maintained by Express Scripts

Where Can Retirees Get More Information?

- Express Scripts Member Website –www.Express-Scripts.com
 - Order mail order refills
 - Download forms
- Members can call Express Scripts Medicare Customer Service at 1-866-557-8211. TTY users should call 1-800-716-3231
- Medicare
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
 - www.medicare.gov
- Social Security Administration
 - 1-800-772-1213. TTY users should call 1-800-325-0778.
 - www.ssa.gov

Where Can Retirees Get More Information?

- Open Enrollment packet
- EBD website <u>www.dbm.maryland.gov/benefits</u>
- EBD Customer Service 410-767-4775 or 800-307-8283
 - Onsite EGWP rep available during OE

Questions



Frequently Asked Question #7

If an employee turns 65, but is going to remain actively employed, does the employee need to enroll in Medicare?

Welcome to the World of Health Benefits after Retirement

Based on responses from the recent OPSB survey, we want to teach you the basics about retirement health benefits and Medicare.

Health Benefits after Retirement

- If employee's Hire Date is prior to 7/1/2011 and retirement directly follows State service, will be eligible for health benefits if:
- has at least 5 years of creditable service; or
- is approved for a State disability retirement.
- If employee's Hire Date is prior to 7/1/2011 but retirement does not directly follow State service, will be eligible for health benefits if:
 - ended State service with at least 16 years of creditable service; or
- ended State service with at least 10 years of creditable service AND within five years of normal retirement age; or
 - is approved for a State disability retirement.

Health Benefits after Retirement

- If employee's Hire Date is on or after 7/1/2011 and retirement <u>directly follows</u> State service, will be eligible for health benefits if:
 - has at least 10 years of creditable service; or
 - is approved for a State disability retirement.
- If employee's Hire Date is on or after 7/1/2011
 but retirement does not directly follow State service, will be eligible for health benefits if:
 - ended State service with at least 25 years of creditable service; or
 - ended State service with at least 10 years of creditable service AND within five years of normal retirement age; or
 - is approved for a State disability retirement.

State Subsidy

- Maximum Subsidy Available if employee
 - has at least 16 years of creditable service if hired prior to 7/1/2011 or 25 years of creditable service if hired after 7/1/2011; or
 - is approved for a State disability retirement.
- Pro-Rated Subsidy if employee
 - retirees with less than 16 years of creditable service if hired prior to 7/1/2011 or less than 25 years of creditable service if hired after 7/1/2011

Calculating Pro-Rated Subsidy

Divide months of creditable service* by 192 months (16 years) if hired prior to 7/1/2011 or 300 months (25 years) if hired after 7/1/2011

Example:

- •60 months (5 years) ÷ 192 months (16 years) = 0.3125
- •0.3125 (31.25%) of the maximum subsidy is what the State will pay toward benefits.
- •Retiree's monthly cost:
- •0.6875 (68.75%) of the maximum subsidy, **PLUS**
- •the regular monthly retiree premium.

For estimates of premiums with pro-rated State subsidy, call the EBD

*Creditable service includes military, purchased service, and credit for unused sick leave.

Notices Retirees May Disregard upon Retirement

- COBRA Notice
- "No Pay" letter from the EBD
- "Non Group Bill" from your health plan (a conversion bill on health plan letterhead)

These forms are printed automatically due to the change from active to retiree.

Retiree Enrollment Form

- Must be submitted to EBD within 60 days of retirement or retiree will have to wait until the next Open Enrollment.
- If adding new dependents at time of retirement, submit all required documentation with enrollment form.
- The same dependent eligibility criteria apply to retirees as active employees.

Retirement Options and Beneficiaries

Spouse (Opposite and Same Sex)

- Options 2, 3, 5 and 6
 - Allow a surviving spouse (if designated as retirement beneficiary) to continue coverage with same State subsidy as the retiree
- Options 0, 1 and 4
 - Surviving spouse is not eligible for continued subsidized health benefits
 - Health benefits will be available under COBRA for up to 36 months

Domestic Partner

- Domestic Partner Beneficiaries are not eligible for subsidized group health benefits upon the retiree's death
- COBRA coverage will be available for up to 36 months

Child(ren)

- Not eligible for subsidized health benefits unless he/she would meet the criteria for Dependent Child coverage if the retiree were still living
- Subsidized coverage will end when the child no longer meets the eligibility criteria.

Plans Available to Retirees

- Medical Plans
- Prescription Plan
- Dental Plans
- **Term Life Insurance** If enrolled at the time of retirement, can continue or decrease coverage; <u>may not</u> increase or add coverage upon or after retirement. Coverage decreases starting at age 65 for retirees.
- Long Term Care Complete a conversion form within 90 days of your last day of employment to continue same coverage; payments are made directly to The Prudential Insurance Company of America

Plans NOT Available to Retirees

- Flexible Spending Accounts According to federal regulations, the plan will only reimburse eligible expenses incurred while still an active employee
- Accidental Death & Dismemberment Plan- Can convert to a private policy with Minnesota Life within 30 days of ending active employment

Coordination of Care

- If retired and Medicare eligible due to
 - Age (at age 65) or
 - Disability (at any age)
 Medicare is the primary insurer;
 the State plan is secondary to Medicare.
- Parts A (hospital) & B (medical) are required for full coverage.
 Without Part B, member will be responsible for approximately 80% of claim costs that Part B would have covered.

Coordination of Care Example

If member has

- Medicare Parts A & B as primary insurer, and
- State Retiree Group coverage as secondary insurer

Copay Example

Medicare will pay the Medicare-allowed amount and the State plan will pay the balance = \$0 co-pay.

Coinsurance Example

Medicare will pay 80% and the State plan will pay 90% of the remaining 20% for PPO and POS and 100% of the remaining 20% EPO.

Medicare Enrollment

- Retiree should contact Social Security approximately 3 months prior to turning 65 to learn about enrolling in Medicare Part A & B.
- Once enrolled retiree should contact EBD with Medicare 's Health Insurance Claim Number (HICN).

Medicare Initial Enrollment Period

Month You Enroll	Month Part B Coverage Begins	
1 ^{st,} 2 nd , and 3 rd months		
(3, 2 or 1 month(s) prior to 65 th birthday)	1 st day of month you reach age 65	
4 th month	1 st day of following month (1 month dolay)	
(Birthday month)	1 st day of following month (1 month delay)	
5 th month	Two month delay	
(1 month after 65 th birthday)		
6 th month or 7 th month	Three month delay	
(2 nd or 3 rd month after 65 th birthday)	Three month delay	
8 th month & beyond	Must wait for Medicare Open Enrollment	

Exception:

- If born on the 1st day of the month:
 - Seven-month IEP begins and ends one month earlier;
 - Eligible for Medicare month before reaching age 65.

Special Enrollment Period

There is a Special Enrollment Period (SEP) for Part B, when:

- moving from an active employee-group to a retiree-group coverage, and
- Member does not turn age 65 within six months (before or after) the month employee-group coverage ends.

When moving from an active employee group to a retiree group coverage, the penalty for delayed enrollment in Part B is waived.

Exception: If employee group coverage ends during the Initial Enrollment Period, Special Enrollment Period rules do not apply. Contact Social Security in the first three months of the Initial Enrollment Period (the three months prior to reaching age 65) to find out how to make Part B coverage being with retirement.

Medicare Enrollment Periods

Part B:

Enrollment Period: January 1 - March 31

Effective: July 1

If member was eligible but not enrolled in Medicare and did not have health benefits coverage under an active group policy, the Part B premium will be penalized 10% for every 12 months the member was entitled to Part B but not enrolled.

Part D:

•Enrollment Period: October 15 – December 7

Effective: January 1

Questions



Question 1:

- Child birth certificate
- Child's parent's birth certificate
- Proof of residency
- Dependent affidavit

See "Required Documentation for Dependents" section of benefits guide

Question 2:

EBD may send amount due to the State Central Collections Unit (CCU) for collections.

Reminder: There will be a 17% fee added to the amount due by CCU.

Question 3:

December 31, 2014

Reminder: No new same sex domestic partners or domestic partner's children can be added onto the State of Maryland plans as of July 1, 2013.

Question 4:

Will be paid as an in-network claim because the surgery was done in an in-network facility.

Question 5:

Through a retroactive adjustment if OJI leave is 3 pays or less.

Reminder: check and the retroactive adjustment form must be mailed together to the PO Box.

Question 6:

Required by IRS under Section 125

Question 7:

No, the employee can wait to enroll in Medicare until he/she actually retires.

Reminder:

- Applies to spouse as well.
- Due to enrollment in an employer group health plan.

EBD Updates



Dedicated ABC Contact

- Patricia Hawkins
 - **410-767-0656**
 - patricia.hawkins@maryland.gov
- Tominik Williams
 - **410-767-4867**
 - tominik.williams@maryland.gov
- Helena Larry (backup)
 - **410-767-4963**
 - helena.larry@maryland.gov

^{**}Remember – if you email – no names in subject line!**

New Coordinator 101

- Onsite Training at EBD Office.
- Pilot training occurred in August 2013.
- Using feedback from pilot session to do program upgrades.
- Starts December 2013
- Sign up emailing Nneka Dixon.

EBD Website Reminders

Whiteboard



www.dbm.maryland.gov/benefits

EBD Website Reminders

- Open Enrollment tab automatic during OE
- CY14 materials: located under Open Enrollment tab through December 8, 2013.
- SPY13 materials: located under forms, rates, benefits guide tab through December 8, 2013.
- Forms
 - Employee-facing forms: Under the "Forms" tab
 - ABC-facing forms: Under the "ABC Corner" tab

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Questions



We Appreciate All You Do! Thank you!





